TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Methodist Ambulatory Surgical Hospital NW

Respondent Name
Southside ISD

MFDR Tracking Number
M4-15-2307-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 24, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the facility was first notified that this was a Workers Compensation Claim when they received a letter from Edwards Claims Administration dated July 8, 2014 asking for the claim and records to be submitted to them for processing."

Amount in Dispute: $25,644.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "If the provider elects to participate in the workers' compensation arena, the preauthorization rules are applied and required. As such, the requestor is not entitled to reimbursement from the workers' compensation carrier."

Response Submitted by: Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2014	Outpatient Hospital Services	$25,644.66	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduce for absence of precertification/authorization
   - 18 – Duplicate claim/service
   - 193 – Original payment decision is being maintained

Issues

1. Do the services in dispute require prior authorization?
2. Is the Carrier liable for the services in dispute?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code "197 – Payment denied/reduced for absence of precertification/authorization." 28 Texas Administrative Code §134.600 (p) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;" Review of the submitted documentation finds no evidence of prior authorization. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.
2. 28 Texas Administrative Code §134.600 (c) states, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or (D) when ordered by the commissioner;" The Division finds the definition of emergency is not met nor was their prior authorization of outpatient hospital services. Therefore, the Carrier is not liable for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.